TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OrthoTexas Physicians and Surgeons

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-0912-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim is for the causation letter that was requested … for the BRC …"

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.120(b) states an insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title. The Office of Injured Employee Counsel requested the causation latter from the requestor not Texas Mutual. No payment is due for code 99080."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2016	Medical Narrative (99080)	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.120 sets out the procedures and reimbursement for medical documentation.
3. Texas Labor Code §404.002 establishes the Office of Injured Employee Counsel administrative attachment.
4. Texas Labor Code §404.101 defines the general duties of the Office of Injured Employee Counsel.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 284 – No allowance was recommended as this procedure has a Medicare status of 'B' (Bundled).
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

Is Texas Mutual Insurance Company (Texas Mutual) responsible for reimbursement of the service in question?

Findings

OrthoTexas Physicians and Surgeons is seeking reimbursement of $100.00 for a medical narrative provided on August 1, 2016. Reimbursement of medical narratives is subject to the requirements of 28 Texas Administrative Code §134.120, which states, in relevant part, "(d) If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information."

The documentation submitted to the division includes a letter dated July 22, 2016, requesting the medical narrative in question. The letter is on Office of Injured Employee letterhead and signed by an ombudsman. Texas Labor Code §404.002(b) administratively attaches the office to the division, but specifies that the office is independent of the division. For this reason, the letter does not constitute a request from the division per 28 Texas Administrative Code §134.120(e).

Texas Labor Code §404.101(b)(2)(C) states that OIEC shall "assist injured employees, through the ombudsman program, in the division's administrative dispute resolution system." The division concludes that the injured employee requested the medical narrative with the assistance of OIEC in accordance with Texas Labor Code §404.101(b)(2)(C). Therefore, per 28 Texas Administrative Code §134.120(d), Zurich is not responsible for the reimbursement of the service in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.